Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ahmed Khalifa

Respondent Name
Guardian Industries Corp

MFDR Tracking Number
M4-13-0606-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
November 2, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I find that the CPT codes or 95900 & 95904 were not reimbursed. These are billable and valid codes, but when this claim was processed, the EMG billing was about to change to add the modifier KX to the EMG & NCV codes. All of these procedures were performed in the physician's office and were performed by the physician, all on the same day."

Amount in Dispute: $623.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "upon receipt of the MDR, we sent this date of service back for reconsideration and it was determined that an additional allowance is due in the amount of $185.92. Attached is copy of the payment information and an updated EOR."

Response Submitted by: ESIS South Central WC Claims, P.O. Box 6563, Scranton, PA 18505

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 24, 2012	Physician Services	$623.88	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 236 – This procedure pr procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the Nation Correct Coding initiative.
   - W1 – Workers Compensation Jurisdictional Fee Schedule Adjustment.

Issues

1. Did the requestor support the disputed services were separately payable?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as 236 – "This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the Nation Correct Coding Initiative. 28 Texas Administrative Code §134.203(c)(1) states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

   Review of associated NCCI edits for the disputed services finds: Per CCI Guidelines;

   1. Edit Conflict – Medicare Unbundle - Procedure Code 95900 has a CCI conflict with procedure ode 95861. A modifier is not allowed.
   2. Edit Conflict – Medicare Unbundle - Procedure code 99504 has a CCI Conflict with Procedure Code 95861. A modifier is not allowed.
   3. Edit Conflict – Medicare Bundled Item or Service - Per Medicare guidelines procedure code A4556 is an item or service that has no separate payment under the physician fee schedule.

   Compliant with 28 Texas Administrative §134.203 guidelines, the carrier's denial based on CCI edit conflicts is supported.
2. The services in dispute are not separately payable. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.